RITE CARE PERFORMANCE INCENTIVE PROGRAM

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Background on RIte Care

RIte Care is the State of Rhode Island's managed health care program for families on Medicaid, uninsured families with incomes up to 185 percent of the Federal poverty level (FPL), and uninsured pregnant women and children under 19 from families with incomes up to 250 percent of the FPL. Begun in 1994, the goals of RIte Care are to improve access to and quality of care and health outcomes while containing costs. Administered by the Center for Child and Family Health within the Rhode Island Department of Human Services (DHS), eligible individuals are enrolled in three State-licensed health maintenance organizations (HMOs, or Health Plans), which are paid a monthly capitation to provide or arrange for covered in-plan services. Out-of-plan services are paid through the State's Medicaid fee-for-service system.

Over time, Medicaid in the State has been moving from being an after-the-fact payer of services to a value-based purchaser that can leverage its buying power to obtain better and more cost-effective services and delivery systems for enrollees. This value-based purchasing "enables Medicaid to promote better outcomes for the consumer and to gain more overall value for the public dollar."[1]

Purpose of the Performance Incentive Program

In keeping with the State's strategy of using RIte Care to transition Medicaid from a payer to a performance-based purchaser, the contracts with the Health Plans promote comprehensive, coordinated health care delivery and specify access and quality standards that are monitored by the State. Since July 1, 1998, the contracts with the Health Plans have also specified administrative, access, and clinical measures that form the core of a Performance Incentive Program. Each measure has a *standard*, which represents the State's expectation for performance.

Under the Performance Incentive Program, Health Plans can earn payments over and above capitation payments for the attainment of administrative, access, and clinical goals. DHS offers each Health Plan monetary incentives[2] as a reward for improvements in

[1] Rhode Island department of Human Services. *Rhode Island Medicaid Program: Annual Report Fiscal Year 2002*, 4.

[2] The total incentive pool equals approximately one percent of total capitation payments made to the Health

performance, information accuracy, and the completeness of data submitted. Each Health Plan may earn up to $1.25 per member per month (PMPM) in incentive payments. The State did so "to improve care by using available health plan data on access and outcomes" and "to improve the quality of health plan performance data."[3] This was part of an ongoing strategy of partnership with the Health Plans, with both the State and the Health Plans committed to continuous quality improvement for RIte Care. The "approach leverages a comparatively small amount of money in spotlight areas that DHS considers important."[4]

Description of the Performance Improvement Program

The program began with 21 (now 19) measures in three areas, or categories, of focus: nine (now 8) for the administrative category, five for the access to care category, and seven (now 6) for the clinical category. These measures (which are Attachment M of the RIte Care Health Plan Contract) are included as Appendix A hereto.

Each measure is clearly defined, has a numeric *standard* to be achieved, and has *scoring guidelines*. Table 1 shows the relative value of each of the performance categories (e.g., access). The percentage and PMPM allocations reflect the relative importance of each category to the State, with the *clinical* area being the most important. Within each category, the relative importance to the State that a given measure represents is reflected in the *value* assigned to the measure. As Table 1 shows, these values vary considerably.

Table 1

Potential Performance Incentive Program Payments by Category

Performance Category	Percentage Allocation	PMPM Allocation	Value Range
Administrative	20%	$.25	2.5 – 20
Access	30%	$.375	5 – 35
Clinical	50%	$.625	6 –22
Total	**100%**	**$1.25**	

Measures were selected so that the Health Plans could develop strategies to improve performance. All *administrative* measures are actual requirements of the contract between DHS and the Health Plans. The *access* measures are either contract requirements (e.g., members seeking urgent care must receive services within 24 hours)

Plans.

[3] Dyer, M.B., M. Bailit, and C. Kokenyesi. *Working Paper: Are Incentives Effective in Improving the Performance of Managed Care Plans?*, Center for Health Care Strategies, March 2002.

[4] Rhode Island Department of Human Services. *Rhode Island Medicaid Program: Annual Report Fiscal Year 2001*, 42.

or priority areas for the State (e.g., new adult member receive their first visit with their primary care provider (PCP) within six weeks of enrollment). *Clinical* measures are a mix of Health Plan Employer Data and Information Set (HEDIS®) measures (e.g., cervical cancer screening rates) and areas of particular interest to the State (e.g., prenatal care, using the Kotelchuk Index). Both the *access* and *clinical* measures were selected for their applicability to the characteristics, particularly age and gender, of RIte Care enrollees. Data on the *administrative* measures are collected during on-site reviews of each Health Plan. The RIte Care Encounter Data System provides the information for the *access* and *clinical* measures. Data from 1998 were used to establish the baseline against which later performance is compared.

Five "pilot measures" were added in 2000 and include the following areas:

- Postpartum visit after delivery
- First outpatient pediatric visit for infants born into RIte Care
- Emergency room visits by child enrollees with asthma
- Outpatient visit after discharge for a mental health diagnosis
- Translation assistance

Performance Incentive Program Results

The Health Plans have been making considerable progress towards attaining the standards set forth under the Performance Incentive Program. Table 2 shows that the Health Plans have been able to receive a significant portion of the potential incentive payments as a result of their performance.

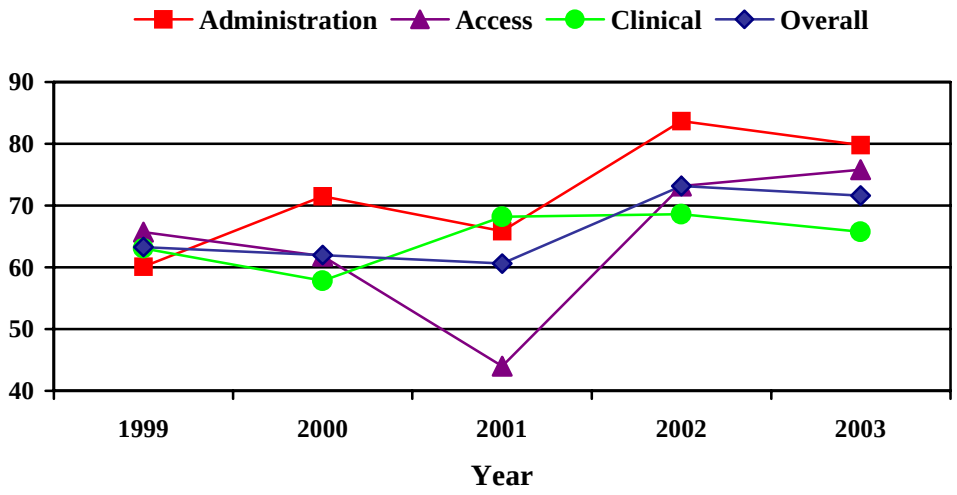
Table 2

Percent of Potential Incentive Payments Received by the Health Plans by Year

Performance Category	1999	2000	2001	2002	2003
Administrative	60.1%	71.5%	65.9%	83.7%	79.8%
Access	65.7%	61.8%	44.0%	73.2%	75.8%
Clinical	63.1%	57.8%	68.2%	68.6%	65.8%
Overall	**63.3%**	**62.0%**	**60.6%**	**73.2%**	**71.6%**

As Figure 1 shows, the trend shows increasing improvement in all three areas and overall by the Health Plans

Figure 1
Percent of Potential Performance Incentive Payments Received by Health Plans over Five Years Show Improvement in All Areas



It should be noted that in 2001, DHS received a Purchaser Award from the National Health Care Purchasing Institute for the program to recognize DHS' "value purchasing" management philosophy. In January 2003, a report[6] from The Commonwealth Fund highlighted that "Rhode Island's experience illustrates that much can be done to improve quality as well as efficiency through relatively modest quality improvement initiatives."

Lessons Learned

The State of Rhode Island believes that its experiences with the Performance Incentive Program to date demonstrate that it is possible for the health care delivery system to respond positively to financial incentives to improve access to and the quality of health care. This does not happen overnight, however; it takes time and concerted work effort to achieve. The State has learned that in order to accomplish this, it has been important to:

- Use a collaborative process
- Provide adequate administrative support
- Structure incentives to reward improvement
- Use measures that are subject to management intervention by the plans to make improvements in performance
- Make certain rewards are real dollars
- Be flexible
- Minimize the burden on Health Plans and the State
- Build on existing processes

[6] Silow-Carroll, S. *Building Quality Into RIte Care: How Rhode Island Is Improving Health Care for Its Low-Income Populations: Field Report*, The Commonwealth Fund, January 2003, 21.

APPENDIX A

PERFORMANCE INCENTIVE SYSTEM MEASURES

PERFORMANCE MEASURE	STANDARD	POINT VALUE
Administrative		
Distribute identification cards within 10 business days of enrollment	98%	2.5
Distribute member handbooks within 10 business days of enrollment	98%	2.5
Assign a PCP to members without a PCP within 20 days of enrollment	95%	10
Answer member calls with an average speed of 30 seconds or less	100%	20
Resolve grievance and appeals within statutory timeframes	97%	20
Pay clean claims within 30 days of receipt by Health Plan	95%	20
Pay claims for medical screening examinations in a hospital ER if a medical emergency exists	100%	10
Notify DHS of any potential source of third-party liability within 15 business days of being known	90%	15
Access		
Members seeking treatment of an emergency medical condition are offered and receive services immediately	100%	5
Members seeking treatment of an urgent medical condition receive services within 24 hours	95%	15
Members seeking treatment of a non-emergent, non-urgent behavioral health condition receive services within 5 business days	75%	10
New adult members receive a first visit with a PCP within 90 days of enrollment	50%	35
New members under age 18 receive a first visit with a PCP within 90 days of enrollment	65%	35
Clinical		
Members under age 2 are immunized according to EPSDT schedule	85%	22
Members between 6 and 20 are provided EPSDT age-appropriate screenings	85%	22
Pregnant members receive adequate or adequate+ prenatal care services	85%	22
Members who reach 18 months of age have an initial lead screen within the preceding 9 months	85%	22
Female enrollees aged 16 to 20 have one or more PAP tests during the past year	40%	6
Female enrollees aged 21 to 64 have one or more Pap tests within the past 3 years	80%	6